

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/25/2016	
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00206767, IN00206773, and IN00207827.</p> <p>Complaint IN00206767 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00206773 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00207827 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 24 & 25, 2016</p> <p>Facility number: 000057 Provider number: 155132 AIM number: 100266570</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 20 Medicaid: 43 Other: 18 Total: 81</p> <p>Sample: 9</p> <p>Danville Regional Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00206767, IN00206773 and IN00207827.</p> <p>QR was completed by 99993 on 08/26/16.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/25/2016
NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	